STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

01/19/2024

CSH Harbour Pointe Lessee LLC
Harbour Pointe Retirement & Assisted Living Center
10200 HARBOUR PLACE
MUKILTEO, WA 98275

RE: Harbour Pointe Retirement & Assisted Living Center License # 2362

Dear Administrator:

This letter addresses Compliance Determination(s) 34806 (Completion Date 01/17/2024) and 26768 (Completion Date 10/16/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/17/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2410-9, WAC 388-78A-2600-2-e, WAC 388-78A-2600-2-l

The Department staff who did the on-site verification:
Allison Nunn, Long Term Care Surveyor

If you have any questions, please contact me at (360)651-6846.

Sincerely, Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Harbour Pointe Retirement & Assisted Living Center
Provider Type: Assisted Living Facility
License/Cert.#: 2362
Intake ID: 88714
Compliance Determination #: 26768
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 07/18/2023 through 10/16/2023
Complainant Contact Date(s): 07/17/2023, 07/18/2023

Allegation(s):

1. The Named Resident (NR) had a change in condition from having altered mentation and becoming nonverbal for two days before being sent to the emergency room for evaluation.
2. The NR may have been having behavior issues and was refusing medications. The NR was not on any medication for high sodium levels.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents Dining Activities Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Administrator Collateral contacts
Record Reviews:	Facility policies Hospital records Email communications with the ALF Care plan Assessments GUardian ship papers Hospice Notes Pharmacy Agreement MAR Disclosure of services. Hospital records Temporary care plan Medication delivery notes Medication summary signed order

Progress notes
After visit summary
Physician Notification
Cause of death in hospital records.
Guardian notes and correspondence with ALF

Investigation Summary:

1. The Assisted Living Facility (ALF) followed their protocol and sent the NR to the hospital for evaluation and treatment on [redacted] 2023 and 07/06/2023. Interviews and records review showed the NR was sent to the hospital on [redacted] 2023 for not being responsive when approached by care staff. The ALF called 911 and the NR was sent to the Emergency room. On 07/06/2023, The ALF called 911 and the NR was sent to the hospital due to screaming in pain when being touched and exhibiting hallucinations. Interview and record review showed the NR was verbal but could not follow instructions prior to the hospitalizations. The ALF placed the NR on alert monitoring after the NR came back to the ALF from the hospital on [redacted] 2023.
2. The NR was exhibiting agitation, was assaultive, combative and refusing care. Records review showed the NR did not take the prescribed prescribed medications for 20 days from 06/06/2023 to [redacted] 2023. The ALF failed to document and address the challenging behaviors exhibited by the NR. Failed practice identified. Citations were issued for noncompliance with WACs 388-78A-2410 Contents of resident records, 388-78A-2090 (8) (b) (ii) Full Assessment Topics and WAC 388-78A-2600 (e)(l) Policies and procedures.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 07/18/2023, 10/04/2023 and 07/18/2023 of:

Harbour Pointe Retirement & Assisted Living Center
10200 HARBOUR PLACE
MUKILTEO, WA 98275

This document references the following complaint number(s): 88245, 88714

The following sample was selected for review during the unannounced on-site visit: 2 of 80 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Kim Ripley
Residential Care Services

10/19/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

10-6-2023
Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document in resident records when 1 of 2 residents (Resident 1) had been exhibiting aggressive and combative behaviors. This failure resulted in Resident 1's behavior not being documented, records being incomplete, and placed Resident 1 at risk of not having their care needs identified and a diminished quality of life.

Findings included...

Review of ALF policy 60.405 titled "Wellness Progress Notes" dated 04/01/2017 showed the ALF Wellness Progress Notes are used by Wellness Team Members to document specific information about each resident. The Notes are written using a focus or reason for the Note before the Note is written. The Notes were used to offer a detailed summary of the issues experienced by a resident and the actions taken to assist him/her. The policy showed Documentation is done by exception only, meaning when an issue or concern about a resident occurs, documentation occurs.

Resident 1 was admitted on [redacted]2019 with multiple diagnoses including [redacted]

On 07/18/2023 at 2:44 PM, Staff B, Resident Care Director, stated that Resident 1 had been exhibiting aggressive behaviors and refused medications at times. Staff B stated the ALF followed charting by exception and care staff would document the specific behaviors in the residents' progress notes.

On 07/18/2023 at 3:44 PM, Staff C, Med Tech and Caregiver, stated that Resident 1 was refusing care, was aggressive and resisting care. Staff C stated that Resident 1 was pushing staff. Staff C stated that they documented in the progress notes and reported the behaviors to Staff B.

On 07/18/2023 at 4:00 PM, Staff D, Med Tech, stated that Resident 1 exhibited intermittent behavior from being calm to being aggressive. Staff D stated that Resident 1 was fighting during care by swinging their arms, verbally aggressive and cursing at staff.

On 07/31/2023 at 9:42 AM, Collateral Contact 1 (CC1), stated that the ALF was not able to provide documentation of Resident 1's challenging behaviors when CC1 requested a copy.

Review of a service plan dated 01/09/2023 showed staff were to monitor, observe, report changes, and document the behaviors of Resident 1 as well as the specific interventions to be done.

Review of an assessment for a change of condition dated 06/27/2023 showed Resident 1 was assessed and needed weekly evaluation of behavior management.

Review of Resident 1's Progress notes from June to July 2023 showed no documentation or records showing the ALF evaluated, charted the behaviors, acted, or performed interventions to address the behavioral concerns.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Harbour Pointe Retirement & Assisted Living Center is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(e) When a resident does not have a personal physician or health care provider;

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have a policy in place to guide staff when a resident does not have a PCP and failed to have a policy in place to ensure residents receive their medications as prescribed when a resident runs out of medication when 1 of 1 resident (Resident 1) did not have a current PCP

identified and ran out of medication. This failure resulted in Resident 1 not receiving medications for 20 days and placed Resident 1 at risk of medical complications and increased behavioral disturbance. This failure placed all residents receiving medication assistance at risk for missed medications, unmet care needs, and a diminished quality of life.

Findings included...

Resident 1 was admitted on [redacted] 2019 with multiple diagnoses including [redacted] Review of Medication Administration Record (MAR) dated June 2023 showed Resident 1 was prescribed Quetiapine Fumarate 100 mg one tablet daily and quetiapine fumarate 25 mg 3 times a day respectively for anxiety, Acetaminophen 325 mg tablet 2 times a day for fever and pain, Divalproex SOD 125 mg SPRK cap 2 times a day for agitation, Metoprolol Tart 25 mg TB (Lopressor 25 mg tab) 1 tablet 2 times a day for Afib (Atrial fibrillation), Senna 8.6 mg tablet one table every morning and trazodone 100 mg tablet 1 tablet at bedtime for difficulty sleeping.

Review of the MAR delivery history for June 2023 showed Resident 1 had not received the following medications from the 06-06-2023 to 06-26-2023 because the medications were not available, and the ALF was waiting for Resident 1's new primary care physician to order the medication:
1. Acetaminophen 325 mg 2 tablets 3 times a day.
2. Divalproex SOD 125 mg SPRK cap 2 times a day.
3. Metoprolol Tart 25 mg TB (Lopressor 25 mg tab) 1 tablet 2 times a day.
4. Senna 8.6 mg tablet one table every morning.
5. Trazodone 100 mg tablet 1 tablet at bedtime.

Resident 1's undated Face sheet showed Collateral Contact 7 (CC7) as the PCP.

Review of the MAR delivery history for June 2023 showed Resident 1 did not received the medications from the 06-06-2023 to 06-26-2023. The MAR notes showed medications "held" due to "medication not available", and "hold" due to the ALF "waiting for new PCP".

On 09/15/2023 at 8:02 AM, Collateral Contact 3 (CC3), LPN from the office of CC7, stated that they were previously Resident 1's PCP. They went on inactive status on 11/10/2023 while the Resident was on Hospice services. CC3 stated that care was reestablished on 06/23/2023 when the new PCP(CC8) (from the same clinic as CC7) was able to see Resident 1 and renew the ongoing prescription.

Review of Resident 1's Medication summary dated 06/26/2023 showed medications were ordered and signed by CC8, Resident 1's new PCP on 06/26/2023 after care was reestablished.

On 08/30/2023 at 11:10 AM, Staff B, Resident care director, stated that CC7, Primary care physician (Initial PCP), refused to refill because they were no longer the PCP.

On 09/22/2023 at 8:31 AM, Collateral Contact 6 (CC6), Hospice Nurse Manager, confirmed that Resident 1 started hospice services on 11/10/2022 and ended on 05/03/2023. CC6 stated that their physician was ordering the medications for Resident 1 during the time of hospice services.

On 09/13/2023 at 12:31 PM, Staff B, RCD stated that Resident 1 did not have the medications refilled because Resident 1 did not have a PCP. Staff B stated that it is not the ALF's responsibility to get Resident 1 a PCP. Staff B stated that Resident 1 ran out of medications on 06/02/2023.

On 09/19/2023 at 2:04 PM, Staff A, ED stated that they do not have a policy regarding non-availability of medications or on what to do to ensure a resident will have continued supply of medication as prescribed.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Harbour Pointe Retirement & Assisted Living Center is or will be in compliance with this law and / or regulation on (Date) 10.6.23 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date: 11.6.23